

MEDICAL REVIEW BRANCH – RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

**INLAND EMPIRE HEALTH PLAN
MEDI-CAL AUDIT REPORT**

Contract Number: 04-35765

Audit Period: October 1, 2017
Through
September 30, 2018

Report Issued: January 17, 2019

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I. INTRODUCTION

Inland Empire Health Plan (IEHP or the Plan) was established on July 26, 1994 as the local initiative Medi-Cal Managed Care Health Plan in the Inland Empire. The Plan received its Knox-Keene license on July 22, 1996 and commenced operations on September 1, 1996 in Riverside and San Bernardino counties.

Inland Empire Health Plan provides managed care health services to Medi-Cal beneficiaries under the provision of Welfare and Institutions Code, Section 14087.3. The Plan is a public, non-profit Joint Powers Agency, Knox-Keene licensed health plan. Inland Empire Health Plan headquartered in Rancho Cucamonga, California, created by Riverside and San Bernardino counties as a two-plan Medi-Cal managed care model.

Inland Empire Health Plan provides health care coverage to eligible members in San Bernardino and Riverside counties for which it is licensed as a mixed model Health Maintenance Organization (HMO). The Plan contracts with approximately 19 Independent Physician Associations (IPAs) and 32 hospitals. The Plan also directly contracts with 1,212 Primary Care Physicians (PCPs) and 2,232 Specialists.

As of September 1, 2018 Inland Empire Health Plan's member enrollment for its Medi-Cal line of business was 1,213,130 and 26,557 for Cal MediConnect, with a total enrollment of 1,239,687 members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of October 1, 2017 through September 30, 2018. The onsite review was conducted from September 24, 2018 through October 5, 2018. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on December 12, 2018 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The Plan submitted supplemental information after the Exit Conference which is reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit report issued February 9, 2018 (for audit period October 1, 2016 through September 30, 2017) identified a deficiency in Access and Availability of Care that was addressed in the Corrective Action Plan (CAP). The CAP response letter dated March 21, 2018 confirmed the previous audit finding was closed.

The summary of findings by category are as follows:

Category 1 – Utilization Management

Review of prior authorization and appeal request for appropriate and timely adjudication yielded no findings during this audit period.

Delegation oversight review yielded no findings during this audit period.

Category 2 – Case Management and Coordination of Care

Review of the Plan's basic and complex management program yielded no findings during this audit period.

Category 3 – Access and Availability of Care

During the prior year audit, the Plan did not have procedures to monitor wait times in provider offices. The Plan submitted a CAP to correct the deficiency by establishing a process to collect self-reported wait times at provider offices, enhanced collection of wait times during provider office visits, and developing a new annual study to assess wait times along with upward reporting to the Quality Improvement Subcommittee.

Review of the Plan's ability to provide member access to covered services yielded no findings during the audit period.

Category 4 – Member's Rights

The Plan did not refer all clinical grievances to a medical director for resolution. Therefore, the Medical Director did not make the final determination on all clinical grievances.

The Plan did not classify all member expressions of dissatisfaction as grievances during inquiry calls. A function of the Plan's member service department is to assist members during inquiry calls to resolve the issue, and any oral expression of dissatisfaction should be considered as a grievance.

Category 5 – Quality Management

Review of the Plan's quality improvement and monitoring system yielded no findings during the audit period.

Category 6 – Administrative and Organizational Capacity

Review of the Plan's health education system and organizational capacity to guard against fraud and abuse yielded no findings during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS), Medical Review Branch to ascertain medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Two-Plan Contract.

The audit evaluated six categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity. In addition, the Plan's Senior, Persons with Disabilities (SPD) population was included in this review period.

PROCEDURE

The onsite review of the Inland Empire Health Plan (IEHP) was conducted from September 24, 2018 through October 5, 2018. The audit included review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 21 (including eight medical, eight SPD, and five pharmacy) prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeals Process: 10 medical (including four SPD) prior authorization appeal requests were reviewed for appropriate and timely adjudication.

Delegated entity onsite review: The delegated entity servicing the greatest number of both Medi-Cal and Cal MediConnect membership was selected for review from the Plan's Delegation Matrix. However, the Plan's oversight efforts identified deficiencies that resulted in termination of the delegate during the review period. Therefore, an onsite visit to the selected delegate was not warranted.

Category 2 – Case Management and Coordination of Care

Complex Case Management: 10 medical records were reviewed for evidence of continuous tracking, monitoring, and coordination of resources to members who received complex case management services.

Behavioral Health Treatment (BHT): 10 charts were reviewed for compliance with BHT provision requirements.

Initial Health Assessment: 10 medical records were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Appointment Availability: 15 contracted providers sampled from the Provider's Directory were reviewed to determine appointment availability. The Provider's Directory was reviewed for accuracy and completeness.

Emergency Service and Family Planning Claims: 20 emergency service claims and 20 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 60 quality of service grievances (including eight SPD) were reviewed for timely resolution, appropriate response to complaint, and submission to the appropriate level for review.

Confidentiality Rights: 10 cases were reviewed for proper reporting of suspected or actual breach of privacy incidents to the appropriate entities within the required time frames.

Category 5 – Quality Management

Provider Qualifications: 10 contracted providers were reviewed to determine if they received Medi-Cal Managed Care program training within the required time frame.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: 10 cases were reviewed for proper reporting of all suspected fraud and/or abuse to the appropriate entities within the required time frame.

A detailed description of the finding for Category 4 is contained in the following report.

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CATEGORY 4 – MEMBER’S RIGHTS

4.1	GRIEVANCE SYSTEM
<p>Member Grievance System and Oversight: Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c). 2-Plan Contract A.14.1</p> <p>Contractor shall implement and maintain procedures...to monitor the Member’s grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858....(as required by Contract) 2-Plan Contract A.14.2</p> <p>Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e). 2-Plan Contract A.14.3.A</p>	

SUMMARY OF FINDINGS:

4.1.1 Clinical Grievance Determinations

The Plan shall implement and maintain procedures... to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Plan’s medical director. *(Contract, Exhibit A, Attachment 14 2(E))*

The Plan shall implement and maintain “procedures to ensure that the person making the final decision for the proposed resolution of a grievance...is a health care professional with clinical expertise in treating a Member’s condition or disease if any of the following apply...Any grievance or appeal involving clinical issues.” *(Contract, Exhibit A, Attachment 14 2(G)(3))*

The Plan did not refer all clinical grievances to a medical director for resolution. The Plan’s policy MED_GRV 2 - *Member Grievance Resolution* states, “Grievance staff

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reviews the Provider/Practitioner's response to a grievance...substantiated medical cases and all pertinent information are submitted to the Medical Director for review and approval of the resolution."

Reviewing Registered Nurses (RN) made determinations on quality of care (QOC) grievances and reported Potential Quality Incidents to the Plan's Quality Management Department for Corrective Action. The verification study revealed that seven quality of service (QOS) grievance cases had potential QOC issues in which the reviewing RN made a unilateral decision on standard of care in medical practice, not the Plan's Medical Director. Therefore, the Medical Director only reviewed cases that the reviewing RN determined physician standard of medical care was not met. As a result, the Medical Director did not make the final determination on all clinical grievances.

During the onsite interview, the Chief Medical Officer (CMO) stated the assigned Medical Director gets involved in QOC cases only when deemed necessary by either the Grievance or Quality Management Department RN. The Plan's CMO and Grievance Oversight Medical Director confirmed grievance staff resolves most QOC grievances and the Medical Director only reviews QOC grievances substantiated by the reviewing RN. The Plan stated to have interpreted the contract to mean only "substantiated" Quality of Care Grievances need a Medical Director review. In addition, the Plan acknowledged its misinterpretation of the contract and Federal regulations and stated that it would revise its policies and procedures.

The contract designates that qualified health care professionals with clinical expertise in treating a member's condition or disease, such as physicians, shall review grievances involving clinical matters to ensure an appropriate level of review. Poor member health outcomes may result if clinical quality problems are not recognized and corrective actions prescribed.

4.1.2 Misclassified Grievances

The Contract defines a member grievance as an expression of dissatisfaction about any matter other than an action (as identified within the definition of Member Appeal).
(*Contract, Exhibit E, Attachment 1, 71*)

Title 28, California Code of Regulations, section, 1300.68(a)(1), states where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

All Plan Letter 17-006 states a complaint is the same as a grievance. Where the Managed Care Plan (MCP) is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance...A beneficiary need not use the term "Grievance" for a complaint

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to be captured as an expression of dissatisfaction and, therefore, a grievance. If a beneficiary expressly declines to file a grievance, the complaint shall still be categorized as a grievance and not an inquiry...the complaint shall still be aggregated for tracking and trending purposes as with other grievances.

The Plan did not classify all member expressions of dissatisfaction as grievances during inquiry calls. A function of the Plan's member service department is to assist members during inquiry calls to resolve the issue, and any oral expression of dissatisfaction should be considered as a grievance. Although the Plan's policy *MC_16A* defines a grievance as an oral or written expression of dissatisfaction by a Medi-Cal Member, review of the Plan's call inquiry log revealed instances in which member dissatisfaction were not classified as grievances.

The Plan provided education and training on the classification criteria to their Member Service Representative (MSR) department in phases. During the onsite interview, the Plan confirmed that not all MSR staff had been fully trained during the audit period and as a result, not all member expressions of dissatisfaction were classified as grievances. To ensure all oral expressions of dissatisfaction are being captured as grievances, the Plan implemented an additional procedure requiring MSR staff to place a follow up call to the member for clarification if a quality assurance supervisor identifies that a potential grievance was missed during the initial call. The effectiveness of this new process could not be tested since it was implemented after the DHCS audit period.

Not properly classifying member dissatisfaction as grievances may result in the Plan not identifying and addressing potential access and quality of care issues.

RECOMMENDATIONS:

- 4.1.1 Revise and implement Plan policy and processes so that qualified health care professionals with clinical expertise in treating a member's condition or disease (such as medical doctors) make the final determination for all clinical grievances.
- 4.1.2 Implement the Plan's policy and monitor the new Member Service Representative process to ensure all oral expressions of dissatisfaction are classified as a grievance.

MEDICAL REVIEW BRANCH – RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

**INLAND EMPIRE HEALTH PLAN
STATE SUPPORTED SERVICES
AUDIT REPORT**

Contract Number: 03-75797

Audit Period: October 1, 2017
Through
September 30, 2018

Report Issued: January 17, 2019

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INTRODUCTION

This report presents audit findings of Inland Empire Health Plan's (IEHP or the Plan) State Supported Services Contract No. 03-75797. The State Supported Services contract covers contracted abortion services with IEHP.

The audit period was October 1, 2017 through September 30, 2018. The onsite audit was conducted from September 24, 2018 through October 5, 2018.

An exit conference was held on December 12, 2018 with the Plan.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Inland Empire Health Plan

AUDIT PERIOD: October 1, 2017 -
September 30, 2018

DATE OF ONSITE AUDIT: September 24, 2018 –
October 5, 2018

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion

Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:

Current Procedural Coding System Codes: 59840 through 59857*

HCFA Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336*

**These codes are subject to change upon the Department of Health Care Services (DHCS) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*

(Contract Exhibit A, (4))

SUMMARY OF FINDING:

The Plan agrees to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Coding System Codes 59840 through 59857 and Health Care Finance Administration (HCFA) Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services (DHCS) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract. *(Contract, Exhibit A, (4))*

Policy# OPS/CLM P-13: *State Supported Services Abortion* states, Abortion is covered by the Medi-Cal program as a physician service. Members have the right to access abortion services through a contracted or non-contracted qualified provider and services are generally rendered on an outpatient basis. Additionally, Abortion services and related supplies do not require prior authorization. However, if the abortion services require inpatient hospitalization, the inpatient facility services (only) require authorization.

The onsite interview confirmed the Plan provided State Supported Services to its members and all required procedure codes were verified within their billing system. There were no deficiencies noted during this audit period.

RECOMMENDATION:

None